Providing high quality, affordable health care for every child

Written testimony by the Honorable Chris Gregoire
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Chairman Pallone, Ranking Member Deal, and Members of the Committee: for the record, my name is Chris Gregoire, Governor of Washington. Thank you for the opportunity to discuss Washington State's work over the past several years to ensure that every child has access to health care in our state.

When I first came to office a little over three years ago, one of my very first acts as governor was to stop 19,000 children from being dropped from health care coverage by directing the then-Secretary of our Department of Social and Health Services to do two things: return us from 6-months eligibility reviews to 12-month eligibility reviews for children on our medical programs, and hold back the imposition of premiums for those families living below 200% of the federal poverty level.

That was a defining and moving moment for me – a realization of what I, as Governor, and what we, as public servants, can do on behalf of our communities.

It was also just the beginning – the beginning of my work on health care and, frankly, my understanding about the depth and complexity of our health care challenges.

In 2006, I chaired a Blue Ribbon Commission on Health Care Costs and Access in Washington State. This was a bipartisan commission charged with delivering a five-year plan to provide access to safe, high quality, affordable health care for all Washingtonians.

We learned an inordinate amount about our health care system through this Commission – its challenges, its opportunities, its people, its impact. We agreed that health care is a shared responsibility. It is a three legged stool between government, business and individuals (and in the case of children, their parents).

I also came to understand not only the moral imperative of covering children, but the economic and societal benefits of doing so, as well.

First, we learned that healthy children are *far* more likely to succeed in school and life – that the health of the next generation is critically important to the future of our country.

Second, we heard from pediatricians at one of the country's first class institutions in children's health, the Seattle's Children's Hospital and Medical Center. Their testimony made clear that it is far more costly to taxpayers for children to access care via the emergency room than through routine medical and preventative care.

Third, that by the time children receive care in the emergency room, it is often too late. Their health care conditions are more severe, the consequences to the child more painful, and the costs to society greater.

We also know that uninsured children can sometimes cause other children to get sick in the classroom because their care was delayed.

This is what we know. These are the realities we learned in Washington State.

And it is the reason why Covering All Kids has been a hallmark of my first term, and with bipartisan cooperation in my state, the Legislature has stood with me. It is why we have a comprehensive approach to health care for children.

Beginning in our 2005 legislative session and culminating in the 2007 session, on March 17, 2007, I signed a comprehensive bill that truly lays a strong foundation to ensure that all children living in Washington State have health insurance coverage by 2010.

In Washington State, we believe that providing health care coverage to all of our kids and making sure they have access to high quality, affordable health care is not only the right thing to do – it is a moral imperative. We know that access to routine and preventive health care services can profoundly affect a child's health and well-being and readiness for school. Healthy children learn better, grow better, and have a better chance of succeeding in life.

WHAT WASHINGTON STATE IS DOING

In the 2005 session, the Legislature codified the goal that all kids in the state of Washington have health care coverage by 2010.

With the legislation passed in 2007, the state is truly looking at children's health care in a comprehensive fashion. It's not just about an insurance card, it's about reimbursement for providers so that children can get in to see a provider. It's about promoting healthy food and physical activity in schools. It's about preventive services and making sure that children are receiving timely vaccinations. It's about ensuring all children have a medical home – in other words, one place that coordinates their care and anticipates their needs.

Specifically, the comprehensive legislation:

- Raised the eligibility rate for all children's programs to 250 percent of FPL, and we anticipate enrolling half of the remaining uninsured children under that limit this biennium.

- Allows for an active outreach effort over the next 18 months.

- Increased reimbursement rates for pediatricians by nearly 50 percent on January 1, 2008.

- Will increase the eligibility rate for all children to 300 percent FPL on January 1, 2009.

- Provides for designing a reimbursement system so that families above 300 percent of FPL, who still cannot afford to purchase health insurance on the private market, will be able to buy children's coverage from Medicaid at the state's full cost. That also will go into effect on January 1, 2009.

- Established a framework to develop and track measures to improve the health care system for children and tie future rate increases to providing a medical home for children and improving their health status.

Providing for our children also takes a partnership and a shared responsibility between government and the people it is intended to serve. The comprehensive legislation I signed made very clear that parents, as well as the government, have a responsibility to provide health care for our children.

A parent's first responsibility is to make sure that a child is healthy and safe; to pay for health insurance if they can afford it; to make sure their child's immunizations are up to date; to ensure that their kids have had their annual check up. And when parents can't afford it, the state will do what it can to help parents meet their responsibilities.

For example, with respect to SCHIP, unlike Medicaid, SCHIP families pay a monthly premium, which is currently $15 a month per child, with the cost capped at three children per family. The premium has not proven to be a barrier to access – in fact there are indications that it lets families demonstrate some responsibility and ownership in the health coverage of their children. And when our eligibility level increases from 250% FPL to 300% FPL in January, the family participation through the monthly premium will also increase on a sliding scale.

In three short years, what Washington has achieved is quite remarkable and results so far are very promising. Our uninsured rate for children has dropped significantly and 84,000 more children have access to health care today than had it in 2005. By our own state population survey, we are covering 94% of children below 200%FPL. (Centers for Medicare and Medicaid Services (CMS) national census data puts us at 91%.) Our state's insurance programs for children currently provide coverage for 583,000 children. Another 1.2 million children are covered by private insurance, most of it in employer plans.

In total, our state is providing subsidized health coverage for one in every three children in Washington. Medicaid also covers just under half of all the births in our state.

Despite these totals, we still have up to 70,000 children in our state without insurance coverage. These children are in families where an employer has cut back coverage or dropped it altogether. They are in self-employed families, which cannot possibly shoulder the cost of the individual market. And they are in families that might even qualify under current eligibility standards, but who do not realize it.

STATE HEALTH PROGRAMS

In Washington State, we have three programs that serve low-income familes:

- Our Title XIX-funded Medicaid program for children provides health coverage up to 200% of the Federal Poverty Level, or FPL.
- Our Title XXI SCHIP program provides coverage to children up to 250% of FPL
- Our recently re-implemented state-only funded Children's Health Program (CHP) with state-only resources provides coverage for non-citizen children up to 250% of FPL.

Just as we have taken a comprehensive approach to children's health, so, too, do we look comprehensively at how parents enroll their children in these programs. With an eye toward simplification, we have taken significant steps to streamline the way in which families enroll their children in state programs:

- We've consolidated the application forms so that one form applies to all three programs – no more worrying about whether you filled out the right form.

- In terms of benefit structure, all three of our children's medical programs have the same comprehensive health benefit package, based on full-scope Medicaid coverage. That avoids confusion – and it makes it easier to move from one program to another without redefining someone's benefits.

- Most importantly, the convergence of eligibility standards means that any child in a Washington State family that meets the 250 percent FPL guideline is eligible to receive medical assistance. State government will navigate through the complexities of program eligibility. The family doesn't have to.

- Except for SSI disabled children, Medicaid and SCHIP children receive coverage through our Healthy Options managed care program. Over time, we will consider having CHP children enroll in managed care, as well as pilots for SSI children.

STATE-FEDERAL PARTNERSHIP

Medicaid and SCHIP provide the backbone for covering uninsured children. To truly cover all children in Washington State – and throughout the nation – we need a partnership of shared responsibility between states and the federal government. It is vital that the federal government show the same unity in purpose as it did when it passed SCHIP in 1997 – with a Republican Congress and Democratic

President – and reauthorize SCHIP now, because it is critical to seeing that all children have access to health care.

I want to thank my Congressional delegation. Throughout the attempts to reauthorize SCHIP, they have been stalwarts. Because Washington State was an early leader in children's coverage, and one of a handful of states to raise Medicaid eligibility to 200 percent of FPL prior to the enactment of SCHIP in 1997, it has been punished ever since by a long-standing inequity that prevented the state from using its full allotment of SCHIP funds. My delegation worked with this committee and others and I want to thank you for including a fix in the SCHIP reauthorization packages sent to the President.

Without SCHIP reauthorization, our state-federal partnership fails to achieve its goal. Without a partnership with federal regulators, we fail again. It is vital that federal regulators stop creating onerous rules that serve only to bar states from carrying out the programs whose stated goals are to ensure access to coverage for children and youth.

In August of last year, the Centers for Medicare and Medicaid Services (CMS) announced that states would no longer be given waiver approval to raise SCHIP eligibility rates above 250 percent of FPL. Since Washington has laid the foundation to go to 300 percent of FPL on January 1, 2009, we are one of 9 states challenging that directive as exceeding their authority and failing to comply with the rule-making responsibility.

The reason my state is challenging CMS is this: Picture the single mother with two children, trying to make ends meet with an annual income of $45,000 a year – just over 250 percent of FPL under 2008 federal guidelines – and imagine how she will pay for lodging, food, clothing and transportation for the kids….and still have $700 to $900 a month left over so that she can buy health insurance. That's roughly one-fourth of her income. This problem does not even go away at 300 percent of FPL in Seattle or even parts of Eastern Washington. In fact, it often times gets more desperate.

Tied to the August 17 guidance letter to states, CMS is requiring that if states intend to increase SCHIP eligibility rates, they must first have to enroll at least 95 percent of the children in families with incomes of up to 200 percent of FPL. Many states have weighed in against this limit because by CMS measurement no state will comply. The effect of the rule intended or otherwise is to preclude the states from covering children in low-income households.

Ironically, Washington State should not be that far off the 95 percent mark. In fact, as mentioned earlier, by our own annual Population Survey, we show that 94 percent of all children in families below 200 percent of FPL have been enrolled in medical assistance programs.

But the CMS measurement will not be based on our state's more accurate measurement of insured rates. Instead, it will likely be drawn from national census figures, which are less accurate and show Washington's rate at closer to 90 percent. By these same measures, only one state to my knowledge does any better. Purportedly, the State of Vermont has a participation rate of 92 percent for its children below 200 % FPL. Again, the "rule" ensures that no state will qualify.

One of the justifications for these new federal limits on our ability to insure our own children is known as "crowd-out." The crowd-out argument suggests that by making public health coverage affordable, families would drop their private coverage and enroll in SCHIP.

In Washington State, we have structured a program to get at that very issue. In creating an Employer-Sponsored Insurance program, or ESI, we work with employer plans in those cases where it is cheaper for Medicaid to pay the premium assessments for parents' employer plans to keep kids in employer plans.

There are several advantages to the ESI program, including the fact that it saves money for the state. But more importantly, it puts a family on the same health plan and lets them form a relationship with a single primary care provider. That's where the concept of medical home takes over, as I mentioned earlier.

Remember. The families taking advantage of our ESI program are already Medicaid eligible. If not for ESI, they would be on the state's caseload. But as it is, the state and federal governments are saving money when we can contribute to the family's premium for ESI at a lower cost than what we would otherwise be paying if the family were still on the Medicaid rolls.

Having successfully identified a mechanism to deal with crowd-out in our Medicaid program, Washington State approached CMS to expand ESI into our SCHIP program. Unfortunately, within the last few weeks, we received a letter from CMS that apparently will veto our plan to add this ESI feature to our SCHIP children's coverage.

Incidentally, the SCHIP bills sent to the President would have kept the Employer-Sponsored Insurance door open for our SCHIP client families, allowing the state to partner with private employers when it saves money for the state.

In addition to requiring unachievable participation rates, the rule is wrong in requiring a child to go uninsured for one full year if that child has had employer sponsored coverage through his or her parent and then is dropped. An entire year before he or she can come onto a state program! Again, as opposed to my state's keen interest in routine and timely care, as well as saving taxpayer resources, this requirement is simply inviting poorer health and greater emergency room utilization.

Another federal barrier to carrying out health care programs in Washington State and the other states is citizenship verification requirements that were remedied in the reauthorization bill passed by Congress.

In 2006, the Deficit Reduction Act dropped an expensive requirement on states to document the citizenship of each Medicaid applicant, from newborn babies on up. Previously, Medicaid programs were allowed to use a sworn statement by applicants, under penalty of perjury, to verify citizenship – an approach the federal Inspector General had ruled to be adequate and workable.

Since the rule took effect, our state Department of Social and Health Services had to devote 38 full-time employees to go through all Medicaid clients currently on the state's rolls at the time of implementation and lay out a process for approving all new applicants at a cost to the state of close to $5 million dollars. In going through all clients on the rolls, I will tell you that out of the over 383,000 clients who had attested to being U.S. citizens, our staff identified only one person inappropriately enrolled in Medicaid – an elderly woman from British Columbia, Canada.

The SCHIP reauthorization bill would have given states the option to make citizenship documentation requirements much easier. Under that vetoed legislation, we would have been allowed to match applicants' Social Security numbers with the Social Security Administration, avoiding the time-consuming and expensive work of collecting original birth certificates and other documents.

The same bill also would allow our Tribes – and in Washington State, there are 29 federally recognized Tribes – to use their Bureau of Indian Affairs identity cards to verify citizenship.

In discussing the need for a stronger partnership between the states and federal government, I would be remiss if I did not mention the frustration that my colleagues and I share with respect to a number of Medicaid regulations being pursued by the Administration around targeted case management, graduate medical education, school-based services, and coverage of rehabilitative services, to name a few.

Joining as we did for our annual winter meeting just this past weekend, governors are united in our opposition to these CMS regulations that will cause significant harm to children, seniors and people with disabilities while shifting greater and greater costs to the states. Estimated to be $15 billion over five years, states simply cannot shoulder these costs and I urge you to delay the implementation of these regulations.

HIGHER QUALITY DRIVES LOWER COSTS

We must not shy away from doing the hard work of re-establishing our partnership to provide health care coverage for our country's children – because we save taxpayers dollars.

As Governor, I face the same challenges that you do at the federal level when it comes to developing a budget (although mine, constitutionally, has to be balanced). There is no question that we all struggle with how to absorb ever increasing costs of health care – families, employers, and government alike.

That is why my efforts in Washington State around children's health fit into a much larger agenda around health care. And that agenda centers on driving down the cost and driving up the quality of care. It's about making the system more affordable and accountable to improve results – to actually improve the health, and the health outcomes, of all Americans.

And that is why our state programs today are models of fiscal integrity and we are actively partnering with the private health industry on ways to share data, implement cost controls and squeeze out waste from existing expenditures. We are

pioneering evidence-based practices and health information technology, expanding chronic care management concepts and using predictive modeling while we integrate medical, mental health and chemical dependency services. We are continuing to look for new ways to bring faster, effective treatments to our clients…and to spend less in doing it.

But the kids come first. Washington State is committed to preparing them to be the very best they can be – with the tools, the education, and the health that they need to succeed and be productive members of our society.

Former U.S. Surgeon General Joycelyn Elders said that it is impossible to educate an unhealthy child, and it is impossible to keep an uneducated child healthy. Every teacher knows that a sick child is not ready to learn. And every parent knows a good basic education is among the best indicators of a healthy future.

Washington State is paving the way. We need your help, though, and continued partnership to make our vision of covering all children by 2010 a reality and I urge reauthorization.

I am attaching a history of medical assistance in Washington State in the event that some of these remarks need additional context.

Thank you for your time, and I look forward to any questions you may have.